

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00716

724

Item 7 FilmG238 1-28-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Hebron</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First <b>W.</b>	Middle <b>ALLEN</b>
4. DATE OF DEATH <b>January 20, 1959</b>		5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>47</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>H. J. Baker, Ellicott City, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Apoplectic Hemorrhage of Left</b> <b>331X</b> <b>Cerebellar Hemisphere</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/20/59</b>
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>	22b. DATE THEREOF <b>1-22-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>West Liberty</b>
22d. LOCATION (City, town, or county) (State) <b>Alpha Md</b>	22e. REC'D. BY REGISTRAR DATE <b>JAN 23 '59</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>	24a. REC'D. BY REGISTRAR DATE <b>JAN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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VOL. 1. 1912. 2. 1913. 3. 1914.

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FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for our files.

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SM 2/57

75. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
95 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00717

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY <b>Howard</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenwood</b></p> <p>c. LENGTH OF STAY IN lb</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b></p> <p>b. COUNTY <b>Howard</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenwood</b></p> <p>d. STREET ADDRESS</p>			
<p>3. NAME OF DECEASED (Type or print) <b>ELIZABETH ANN COTTON</b></p>				<p>First <b>ELIZABETH</b></p> <p>Middle <b>ANN</b></p> <p>Last <b>COTTON</b></p>	<p>4. DATE OF DEATH</p>	<p>Month <b>Jan. 20</b></p> <p>Day <b>1950</b></p>	<p>Year</p>
<p>5. SEX <b>Female</b></p>		<p>6. COLOR OR RACE <b>White</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>9-26-1953</b></p>	<p>9. AGE (In years last birthday) <b>5 yrs.</b></p>	<p>IF UNDER 1 YEAR Months <b>0</b></p>	<p>IF UNDER 24 HRS Hours <b>0</b></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>None</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>John Cotton</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Marion Hoglund</b></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>None</b></p>		<p>17. INFORMANT <b>John Cotton, Glenwood, Md</b></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cremation</b> <input checked="" type="checkbox"/> in burning house</p> <p>916.0 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (b) <b>None</b></p> <p>(c) <b>None</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Dwelling burned to ground</b></p>							
<p>19. WAS AUTOPSY PERFORMED? <b>NO</b></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling burned to ground</b></p>					
<p>20c. TIME OF INJURY Hour <b>1-45 P.M.</b></p>		<p>Month, Day, Year <b>1-20-59</b></p>	<p>20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b></p>	<p>20f. (City or town) <b>Glenwood</b></p>	<p>(County) <b>Howard</b></p>	<p>(State) <b>Md</b></p>
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <b>George E. Burgtoft</b></p> <p>EXAMINER'S NAME (Type) <b>George E. Burgtoft</b></p>				<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED <b>1-20-59</b></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b></p>		<p>22b. DATE THEREOF <b>1-21-59</b></p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Loudon Park</b></p>		<p>22d. LOCATION (City, town, or county) <b>Baltimore, Md</b></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b></p>				<p>24a. REC'D BY REGISTRAR DATE <b>JAN 23 '59</b></p>		<p>24b. REGISTRAR'S SIGNATURE <b>Oathus S. Kline</b></p>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,12 Film G238 2-2-59 et

00718

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer Retreat		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Mrs. Mary R. V.		d. STREET ADDRESS 8636 Old Harford Road	
4. DATE OF DEATH January 21st 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 13, 1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Myers		14. MOTHER'S MAIDEN NAME Margaret Taaband	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs Anna Dailey, 2815 Rueckert Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH acute ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958, to Jan 21, 1959, that I last saw the deceased alive on Jan 19, 1959, and that death occurred at 8:57 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John A. Kochanski</i> M.D. ADDRESS (Street, city or town, state) 1037 W. Calvert St PHYSICIAN'S NAME (Type) Dr. J. A. Kochanski DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59	
22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR JAN 28 '59 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE John S. Ruck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF TRANSPORTATION - STATE OF ILLINOIS

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Clarksville		c. LENGTH OF STAY IN 1b instant.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First Dorothy	Middle Virginia
4. DATE OF DEATH		Last ESTEP	Month January
5. SEX female		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 14, 1914		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house maid		10b. KIND OF BUSINESS OR INDUSTRY private home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Thomas Wilson		14. MOTHER'S MAIDEN NAME Laura Rebecca Henson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215305230	
17. INFORMANT Jesse Wilson, Highland, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> Severe crushing injury to chest (auto acc.) instant.  <b>823X</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b>  <b>DUE TO</b> <b>(c)</b>  <b>DUE TO</b> <b>(d)</b>  <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased driving car skidded on ice and ran into tree. Steering wheel crushed chest.	
20c. TIME OF INJURY 8:45 <sup>AM</sup> <del>XXX</del> 1-2- 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road
20f. (City or town) Clarksville, Howard, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		DATE SIGNED January 2, 1958	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/59	22c. NAME OF CEMETERY OR CREMATORIUM Hopkins Church,
22d. LOCATION (City, town, or county) Highland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snodgrass</i>		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE JAN 8 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. French</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

25

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 13 &amp; 14, Film G-232 1/16/59.cdc

## CERTIFICATE OF DEATH

Reg. Dist. No.

00720

728

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thunder Hill				d. STREET ADDRESS Thunder Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Anna Mae ANNIE H. GOLDSMITH		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 10, 1925	9. AGE (In years lost birthday) 33 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown Amoss W. Herrmann		14. MOTHER'S MAIDEN NAME Unknown Margaret?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT C. Oliver Goldsmith, Ellicott City, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		RESPIRATORY FAILURE				INTERVAL BETWEEN ONSET AND DEATH 24 HRS		
(b) DUE TO METASTATIC BRAIN CANCER						19 MOS		
(c) DUE TO CANCER OF BREAST						13 YRS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 1-8, 1959, to 1-9, 1959, that I last saw the deceased alive on 1-8, 1959, and that death occurred at 2:00 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 1-9-59
ACTUAL SIGNATURE Peter V. Thorpe		M.D.						
PHYSICIAN'S NAME (Type) PETER V. THORPE MD						ELLIOTT CITY, MD		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Louis		22d. LOCATION (City, town, or county) Clarksville, Md		(State)
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR JAN 12 59		24b. REGISTRAR'S SIGNATURE Clifford S. Knott		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

729		Reg. Dist. No.																	
1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland		c. LENGTH OF STAY IN 1b		d. STATE Maryland b. COUNTY Howard															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland																	
d. STREET ADDRESS		e. IS RESIDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First JOHN ANDREW HOLLAND			Middle			Last		4. DATE OF DEATH		Month		Day		Year			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH Aug. 12, 1896		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 MINS. Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Highland, Md		12. CITIZEN OF WHAT COUNTRY?													
13. FATHER'S NAME Craffton Holland		14. MOTHER'S MAIDEN NAME Elizabeth White										Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-1270		17. INFORMANT Laura Wilson, Highland, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO sclerosis Conditions, if any, which gave rise to immediate cause (b) (c) (d), stealing the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Acute			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
Donald E. Fisher														DATE SIGNED					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type) Donald E. Fisher		22c. NAME OF CEMETERY OR CREMATORIUM Hopkins church, Highland Md										22d. LOCATION (City, town, or county) Highland Md (State)							
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 2/2/59		22c. ADDRESS Rockville, Md										24a. REC'D BY REGISTRAR FEB 3 '59		24b. REGISTRAR'S SIGNATURE John S. Fisher					
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swinden																			
VS. A15ME 5M 2/57																			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <i>Elbridge</i>		c. LENGTH OF STAY IN lb <i>3 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1808 Montgomery Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elbridge</i>			
3. NAME OF DECEASED (Type or print) <i>FRANKLIN HENRY JONES</i>		First <i>FRANKLIN</i>	Middle <i>HENRY</i>		
4. DATE OF DEATH <i>Jan 20 1959</i>		5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 22, 1874</i>			
9. AGE (In years last birthday) <i>84 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Conductor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired. Penn. R.R.</i>			
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jones</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Russell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no.</i>			
17. INFORMANT <i>Mr Charles H. Steele</i>		Address <i>Same</i>			
18. CAUSE-OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Myocardial infarction</i> <i>General arteriosclerosis</i> <i>Senility</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i> <i>3 weeks</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Jan 19 1959</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 16 1959</i> to <i>Jan 20 1959</i> , that I last saw the deceased alive on <i>Jan 20 1959</i> , and that death occurred at <i>4:18 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Brumbaugh M.D.</i> PHYSICIAN'S NAME (Type) <i>B B Brumbaugh</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan 23, 1959</i>		22b. DATE THEREOF <i>Jan 23, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Zion Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Liberty Center Ind.</i>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co. 4905 York Road</i>		ADDRESS <i>Elbridge 27 mg</i>		24a. REC'D BY REGISTRAR DATE <i>Jan 23 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>John W. Jenkins</i>					



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

100723

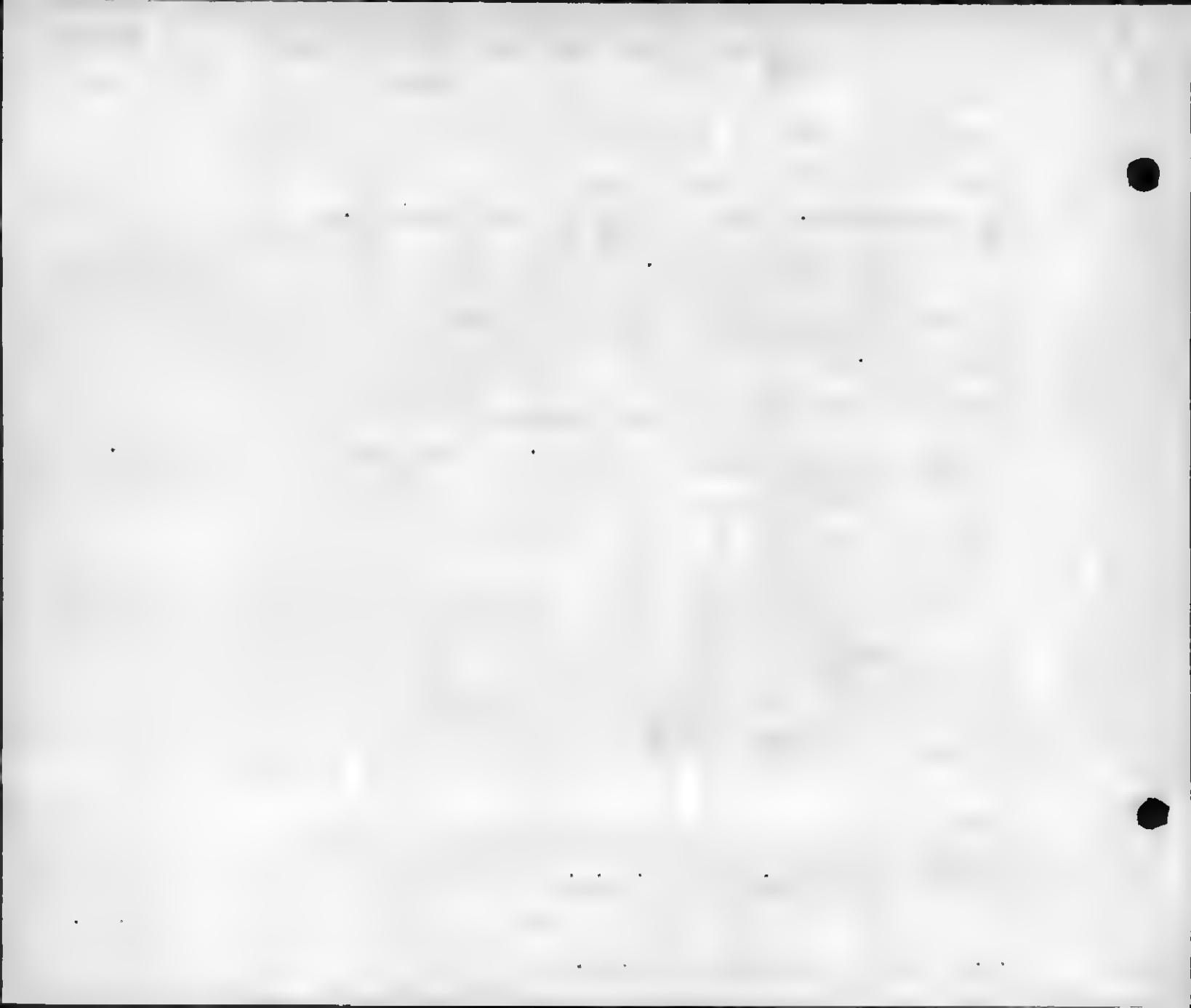
Reg. Dist. No.

731

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 126 Main St.				d. STREET ADDRESS 126 Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH January 28 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1895	9. AGE (in years at birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HRS.	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Attd.		10b. KIND OF BUSINESS OR INDUSTRY Gasoline		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Walter Mc Cauley		14. MOTHER'S MAIDEN NAME Susan Allison						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.L. 215-70-4909		17. INFORMANT Mrs. Edith Mc Cauley, Ellicott City, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PR.MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Thomas F. Herbert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-28-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-31-59	22c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10728

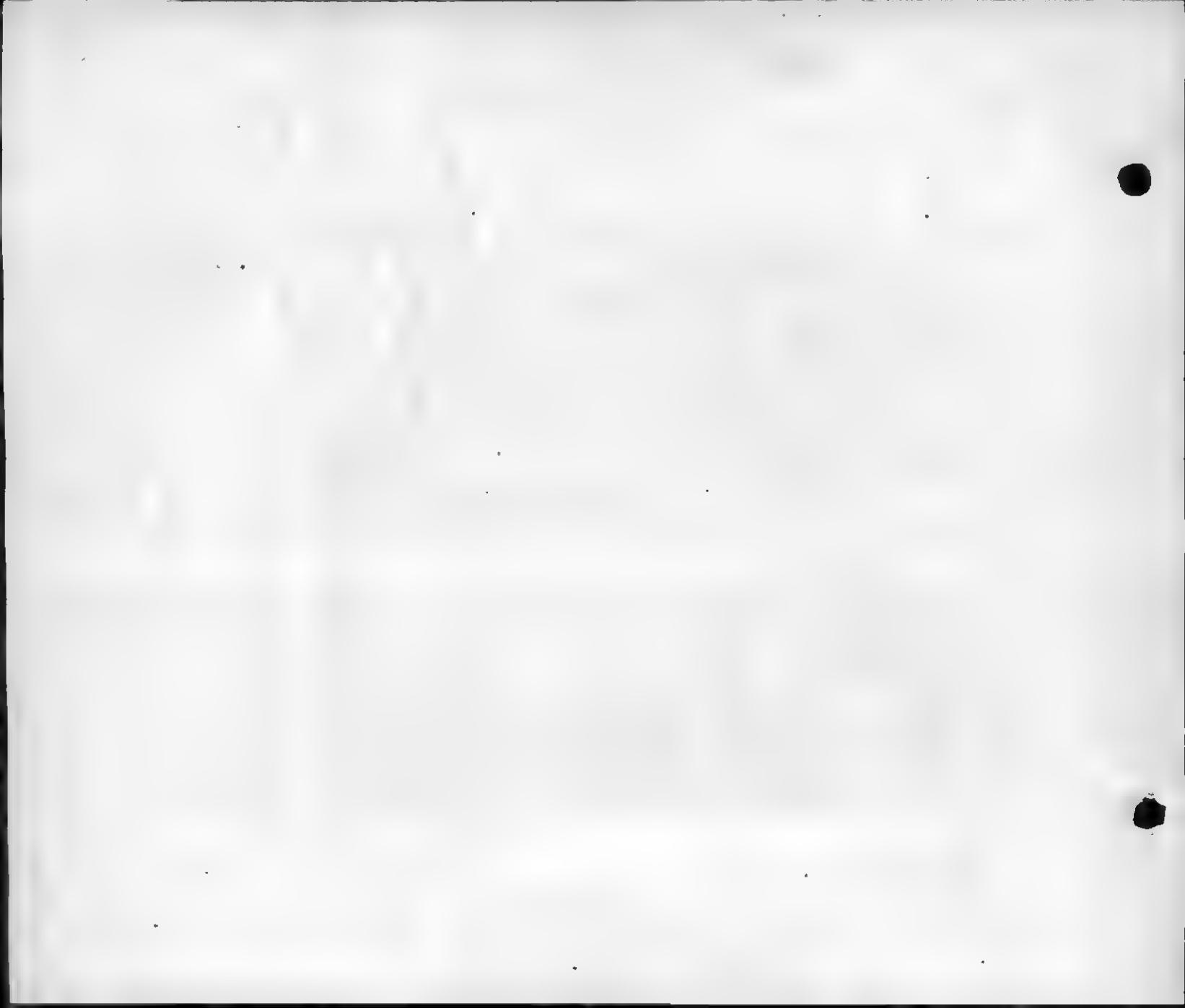
Reg. Dist. No.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15MI  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> <b>rural</b>		c. LENGTH OF STAY IN TB		b. COUNTY <b>Howard</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt.1 Box 24</b>				e. CITY OR TOWN (If outside corporate limit is, write RURAL and give nearest town) <b>Laurel</b> <b>rural</b>	
3. NAME OF DECEASED (Type or print) <b>DENNIS</b> <b>MOORE</b>		First <b>Middle</b> <b>Last</b>		d. STREET ADDRESS <b>Rt.1 Box 24</b>	
4. SEX <b>Male</b>		5. COLOR OR RACE <b>Colored</b>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Aug 1879</b>	
7. AGE (In years last birthday) <b>79</b>		8. IF UNDER 14 YEARS Months <b>7</b> Days <b>78</b>		9. IF UNDER 24 HRS Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Dennis Moore</b>					
14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b> 17. INFORMANT <b>Thos. Snell</b> <b>Laurel, Md.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Viral Gastro enteritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <b>Laurel</b> (County) <b>Md.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Donald E. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>(Columbia : like</b> <b>Ellicott City,</b> <b>1-3-59</b>	
EXAMINER'S NAME (Type) <b>Donald E. Fisher</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Beacons Chapel</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Selby</b>		22d. LOCATION (City, town, or county) <b>Laurel</b> (State) <b>Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 1/6/59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Laurel</b>	



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

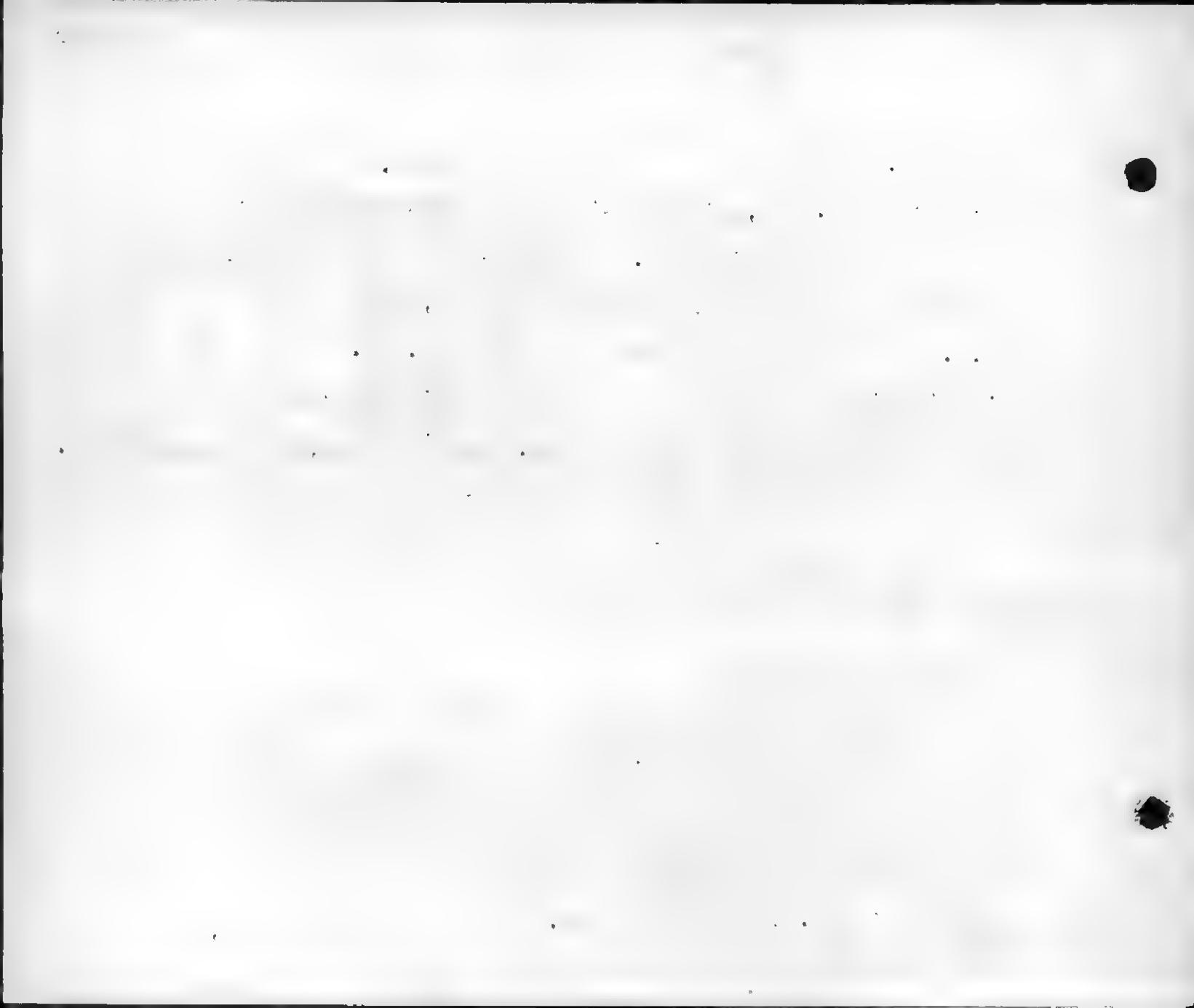
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

733 CERTIFICATE OF DEATH

Reg. Dist. No. 00725

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Howard MARYLAND		a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. (7)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Conv. Home, Ellicott City		d. STREET ADDRESS 5206 Overcrest Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Maggie	Middle M.	Last Roberts
4. DATE OF DEATH	Month Jan.	Day 13	Year 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 16, 1874
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR yrs.	11. IF UNDER 24 HRS Months	12. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Own Home		Balto. Md.	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Philip Airey		Sophia Mentzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT	
		(DAUGHTER) Mrs. Hazel Lumpkin, 5206 Overcrest Rd.	
17. INTERVAL BETWEEN ONSET AND DEATH Cause			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last.		Hyper tension Arteriosclerosis CV Disease	
DUE TO (b)		?	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1</u> , 1958, to <u>Jan. 13</u> , 1959, that I last saw the deceased alive on <u>Jan. 12</u> , 1959, and that death occurred at <u>2414 W. Collett St.</u> M.D. <u>Baltimore 2-464</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Dr. L. A. Kochman</u>			
PHYSICIAN'S NAME (Type) <u>Dr. L. A. Kochman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15/59	
22c. NAME OF CEMETERY OR CREMATORIALoudon Pk.		22d. LOCATION (City, town, or county) (State) Baltimore 29-110	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Directors 4101 Edmondson Ave.		ADDRESS	
		24a. REC'D BY REGISTRAR JAN 19 '59	
		24b. REGISTRAR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

734

## CERTIFICATE OF DEATH

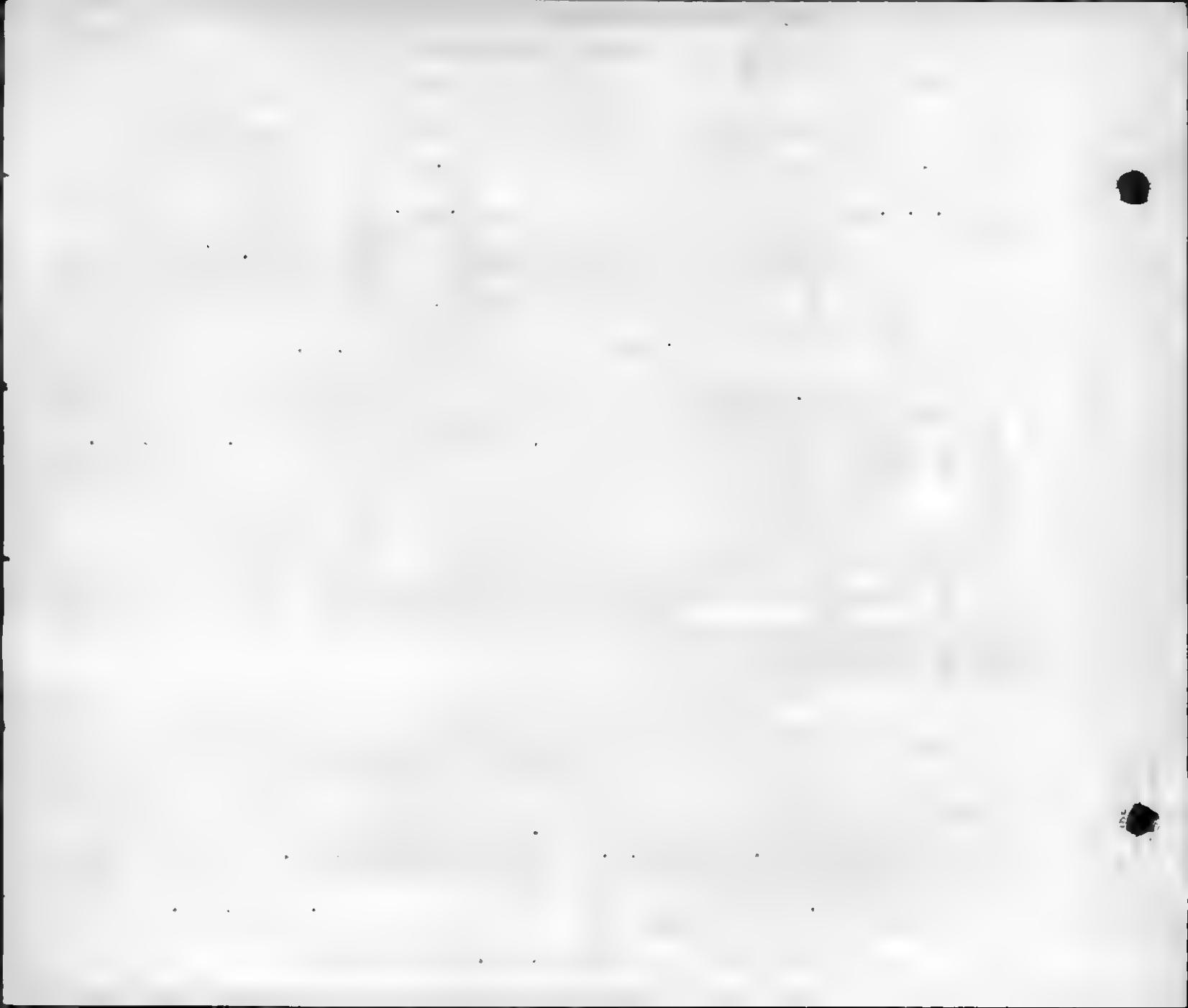
00726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		d. STREET ADDRESS <b>R.F.D. # 3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 3</b>				d. STREET ADDRESS <b>R.F.D. # 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Edna</b>		First	Middle <b>Marie</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>Jan. 22</b>	Month <b>Jan.</b>	Day <b>22</b>	Year <b>19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1895</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Jonathan E. Moxley</b>				14. MOTHER'S MAIDEN NAME <b>Mary O'Sullivan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Willard R. Smith, Mt. Airy, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>						INTERVAL BETWEEN ONSET AND DEATH <b>15 years.</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Damascus, Md.</b>		(County) <b>Damascus</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>February 10, 1955, to January 23, 1959</b> , that I last saw the deceased alive on <b>January 21, 1959</b> , and that death occurred at <b>2:10 AM</b> , from the causes and on the date stated above						ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		
ACTUAL SIGNATURE <i>James P. Kerr</i>						DATE SIGNED <b>1/22/59</b>		
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Pine Grove</b>		22d. LOCATION (City, town, or county) <b>Mt. Airy, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chris L. Moleworth</i>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Peter E. Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

735

## CERTIFICATE OF DEATH

00727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENWOOD		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NEW YEARS GIFT FARM		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENWOOD	
3. NAME OF DECEASED (Type or print) RODERICK		Middle DOWS	4. DATE OF DEATH JANUARY 4 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Wholesale plumbing supplies		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RODERICK D. WATSON		14. MOTHER'S MAIDEN NAME ALICE DOWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW # 1 225-05-1858 17. INFORMANT Mrs. Angela R. Watson, Glenwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CORONARY ARTERY OCCLUSION (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOVEMBER 2, 1957, to JANUARY 4, 1959, that I last saw the deceased alive on JANUARY 2, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>C. S. Whitaker, M. D.</i>		M.D.	
PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.		CLARKSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/7/59	
22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUNSHREY, INC.		ADDRESS SILVER SPRING, MD.	
Raymond D. Ziskai		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

STATE OF CALIFORNIA  
DEPARTMENT OF PUBLIC SAFETY  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF DEATH

DEATH CERTIFICATE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

736

## CERTIFICATE OF DEATH

Reg. Dist. No. 00728

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Laurel)</i>	c. LENGTH OF STAY IN 1b <i>23 yrs</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Laurel)</i>						
3. NAME OF DECEASED (Type or print) <i>Edith Irene Wheatley</i>	d. STREET ADDRESS						
4. DATE OF DEATH <i>January 9 1959</i>	Month Day Year						
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 10 1906</i>	9. AGE (In years less birthday) <i>52 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	11. BIRTHPLACE (State or foreign country) <i>Beaumontville, Virginia</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>				
13. FATHER'S NAME <i>William Curry</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Rodifer</i>	Address <i>James M. Wheatley, Laurel Md</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>James M. Wheatley, Laurel Md</i>	INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphosarcoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <i>Generalized Metastasis</i> <i>Exacerbation</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Entricular fibrillation</i>						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>January</i>	Day <i>19</i>	Year <i>1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Laurel Md</i>	(County) <i>Howard Co</i>
21. I certify that I attended the deceased from <i>9/21</i> , 19 <i>57</i> , to <i>1/9</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/9</i> , 19 <i>59</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Laurel Md</i>			
ACTUAL SIGNATURE <i>B. P. Warren M.D.</i>	DATE SIGNED <i>1/9/59</i>						
PHYSICIAN'S NAME (Type) <i>B. P. WARREN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>January 12 59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge</i>	22d. LOCATION (City, town, or county) <i>Laurel Howard Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur E. Warren</i>	ADDRESS <i>Laurel Md</i>	24a. REC'D BY REGISTRAR <i>Arthur E. Warren</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Warren</i>				
DATE JAN 16 '59							

CEMETERY OF DEATH

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